DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners (ARNPs)
- Blood Banks
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Organizations
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

Memorandum No: 07-85
Issued: December 24, 2007

For information, contact Provider Relations at: 800.562.3022 or http://maa.dshs.wa.gov/contact/prucontact.asp

Supersedes: # Memo 06-108

From: Douglas Porter, Assistant Secretary
Health and Recovery Services Administration (HRSA)

Subject: **Physician-Related Services: Year 2008 Changes and Additions to CPT® and HCPCS Codes, Policies and Fee Schedules**

Effective for dates of service on and after January 1, 2008, unless otherwise specified, the Health and Recovery Services Administration (HRSA) will:

- Begin using the year 2008 Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) Level II code additions as discussed in this memorandum;
- Update the Physician-Related Services Fee Schedule to include the new year 2008 codes, fees, and base anesthesia units (BAU); and
- Update and clarify various policies and payment rates.

Overview

- **All policies previously published remain the same unless specifically identified as changed in this memo.**

- Do not use CPT and HCPCS codes that are deleted in the "*Year 2008 CPT*" book and the "*Year 2008 HCPCS*" book for dates of service after December 31, 2007.

Fee Schedule

- You may view HRSA's Physician-Related Services Fee Schedule on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

Bill HRSA your usual and customary charge.

Maximum Allowable Fees and BAU

HRSA used the following resources in determining the maximum allowable fees and BAU for the Year 2008 additions:

- Year 2008 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;

- Year 2008 Medicare Laboratory Fee Schedule; and

- Current conversion factors.

> **Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT codes and descriptions, HRSA publishes only the official brief description for all codes. Please refer to your current CPT book for full descriptions.

New 2008 Modifiers and Deleted 2007 HCPCS Modifiers

Please review the 2008 HCPCS book for those modifiers that have been added or deleted for the current year. HRSA accepts all modifiers as informational only. Modifier descriptions may be viewed in the 2008 HCPCS book. HRSA may require inclusion of some of the modifiers for payment purposes. HRSA will notify you in future memorandums when a modifier is required for payment purposes.

Deleted CPT and HCPCS Codes

HRSA has incorporated the CPT and HCPCS code updates into the January 1, 2008, Physician Related Services Fee Schedule. HRSA has updated coverage, prior authorization (PA), and fees.

Prior Authorization Update

The following CPT and HCPCS codes require some type of authorization, either PA or expedited prior authorization (EPA). The list below includes both new 2008 codes and existing codes with authorization requirement changes:

J0220
J1743
J2323
27416
83900
83909
88384
88385
99174

Refer to the Authorization section (Section I) of HRSA's current *Physician-Related Services Billing Instructions* for more information.

Prior Authorization Changes

The following procedure codes no longer require PA or EPA:

32855
32856
33254
33255
33256
33886
33944
58548
83037

Note: Procedure code 83037 will no longer require PA when performed in a physician's office; however, it may be billed only once every three months.

The following procedure codes no longer require PA when billed with the following diagnosis codes:

Procedure Code	Diagnosis Code
15170	940.0–949.5 and 906.5–906.9
15171	
15175	
15176	
21198	170.1 and 802.20-802.35

Hysterectomy Consent Form

New hysterectomy procedure codes 58570, 58571, 58572, and 58573 will require a hysterectomy consent form. Use DSHS-approved consent form 13-365. Providers may download DSHS forms at: http://www1.dshs.wa.gov/msa/forms/eforms.html.

Coverage changes

- HRSA has changed the following codes from **noncovered to covered**:

Procedure Code	Brief Description
43752	Nasal/orogastric w/stent
92065	Orthoptic/pleoptic training
92548	Posturography
99315	Nursing fac discharge day
99316	Nursing fac discharge day
S0145	Peg interferon alfa-2 B/10
S9152	Speech therapy, re-eval. **Allowed once per calendar year.**

Note: Procedure codes 99315 and 99316 are not included in the two physician nursing facility visits per month limitation. HRSA allows only one nursing facility discharge per client, per day.

HRSA now covers the following CPT code for initial hospital care:

Procedure Code	Brief Description
99477	Initial day hospital neonate care

- HRSA now covers the following procedure codes without PA when billed with specific diagnoses:

Procedure Code	Brief Description
S2066	Breast GAP flap reconst
S2067	Breast "stacked" DIEP/GAP

See Section F of HRSA's *Physician-Related Services Billing Instructions* for more information.

- HRSA has changed the following codes from **covered to noncovered**:

Procedure code	Brief Description
99318	Annual nursing fac assessment
0174T	Cad cxr with interp
0175T	Cad cxr remote

Updates to Conversion Factors

	7/1/04	7/1/05	7/1/06	7/1/07	1/1/08
Adult Primary Health Care	25.00	24.82	25.51	21.95	24.58
Anesthesia	20.24	20.44	20.99	21.20	21.20
Children's Primary Health Care	34.25	34.56	35.00	31.82	47.10
Clinical Lab Multiplication Factor	.797	.820	.820	.830	.830
Maternity	44.46	44.99	44.71	42.35	42.35
All Other Procedure Codes	22.67	22.71	22.93	22.03	22.03

These conversion factors are multiplied by the relative value units (RVUs) to establish the rates in this fee schedule.

Enhanced Rate for EPSDT Screening Exams for Foster Care Clients

HRSA pays providers an enhanced rate for EPSDT screening exams for foster care clients. Refer to HRSA's EPSDT fee schedule at http://maa.dshs.wa.gov/RBRVS/index.html for specific rates.

Refer to Section C of HRSA's *Physician-Related Services Billing Instructions* for more information.

Foster Children Initial Health Evaluation (IHE)

What is the purpose of an IHE?

The purpose of this evaluation is to identify any:

- Immediate medical, urgent mental health, or dental needs the child may have; and
- Additional health conditions of which the foster parents and caseworker should be aware.

Who is eligible?

Only Clients 18 years of age and younger are eligible for an IHE.

What is included in an IHE?

An IHE includes the following:

- **Careful measurement of height, weight, and head circumference** – This may reveal growth delays or reflect poor nutritional or general health status.

- **Careful examination of the entire body to include the unclothing of each body surface at some point during the examination -** Because some children entering foster care have been victims of physical or sexual abuse, note and document the following:

  - ✓ Any signs of recent or old trauma;
  - ✓ Bruises;
  - ✓ Scars;
  - ✓ Deformities; or
  - ✓ Limitations in the function of body parts or organ systems.

- **Appropriate imaging studies to screen for a recent or healing fracture –** Consider if there is a history of physical abuse before placement or if signs of recent physical trauma are present.

- **Genital and anal examination (male or female).**

- **Laboratory tests for HIV and other sexually transmitted diseases –** Perform when indicated clinically or by history.

- **Documentation and prompt treatment of other infections and communicable diseases.**

- **Evaluation of the status of any known chronic illness -** To ensure that appropriate medications and treatments are available.

> **Note:** Discuss specific care instructions directly with the foster parents and caseworker.

What fee does HRSA pay?

Payment is set at the maximum allowable fee for children's office calls.

To view the EPSDT fee schedule, go to www.maa.dshs.wa.gov/RBRVS/index.html.

> **Note:** HRSA does not pay for an IHE on the same date of service as an EPSDT examination.

How do I bill?

When you provide a foster child with the IHE within 72 hours of entering out-of-home placement, bill HRSA using the following guidelines:

- Bill the appropriate evaluation and management (E&M) code (new patient codes 99201 – 99205 or established patient codes 99211 – 99215);
- Use ICD-9-CM diagnosis code V72.85 as the primary diagnosis; and
- Use modifier TJ.

If you bill an E&M code with the diagnosis code V72.85, but without modifier TJ, HRSA will deny the claim.

> **Important Note:** The IHE is not an EPSDT examination because it is not as complex or thorough. If you feel an EPSDT examination is necessary, perform the EPSDT examination within 72 hours of out-of-home placement and bill HRSA for the exam. The child will not require the IHE.

What are the documentation requirements?

Providers must either:

- Document the IHE on the Foster Care Initial Health Evaluation form (DSHS 13-843); or
- Include documentation in the client's record that addresses all elements addressed in the "What is included in an IHE" section of this memorandum or on the Foster Care Initial Health Evaluation form.

To view and download the Foster Care Initial Health Evaluation form, go to http://www1.dshs.wa.gov/msa/forms/eforms.html and scroll down to the appropriate form number.

New Procedure Code for Implanon™ (Birth Control)

Effective January 1, 2008, HRSA will cover procedure code J7307 for Implanon™ (implantable hormonal contraceptive). See Section H of HRSA's *Physician-Related Services Billing Instructions* for more information.

Injectable Drug Updates

- HRSA updates, on a quarterly basis, the maximum allowable fees for drugs administered in a kidney center. These quarterly drug updates are posted online only. For current Injectable Drug Updates, visit HRSA on the web at: http://maa.dshs.wa.gov. Click **Provider Publications/Fee Schedules**, then **Accept**, then **Fee Schedules**; then click the file with the most current date under the heading **Injectable Drugs**.

- HRSA is changing the procedure code that providers may use to bill for Hyalgan from Q4083 to J7321 and Synvisc from Q4084 to J7322.

- HRSA is adding Euflexxa (procedure code J7323) and Orthovisc (procedure code J7324).

See Section C of the *Physician-Related Services Billing Instructions* for policy and guidelines.

New Lab Panel Code

HRSA now pays for CPT lab panel code 80047.

Prenatal Diagnosis Genetic Counseling

HRSA clarified the prenatal genetic counseling policy in Section G of HRSA's *Physician-Related Services Billing Instructions*.

Psychiatric Admissions

Admissions for acute, community psychiatric inpatient care require PA from the designated Mental Health Division Designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the prior authorization. DSHS has modified the Initial Certification Authorization for Admission to Inpatient Psychiatric Care form (DSHS 13-821). Payment will not be issued for community inpatient psychiatric care if the form is not attached to the bill. See Section E of HRSA's *Physician-Related Services Billing Instructions* for more information.

Psychiatric Diagnostic Interview Examinations

HRSA limits providers to one psychiatric diagnostic interview examination (CPT codes 90801 or 90802) in a calendar year. If a second examination is needed because of a change in the client's condition, HRSA requires PA for the second examination. See Section E of HRSA's *Physician-Related Services Billing Instructions* for more information.

HRSA-Approved Sleep Study Centers

- HRSA is adding the following sleep study center:

HRSA Approved Sleep Centers	Location
Forks Community Hospital	Forks, WA
Tri-State Memorial Hospital Sleep Diagnostic Services	Tri-State Memorial Hospital Inc. - Clarkston, WA
Whidbey General Hospital Sleep Disorders Clinic	Oak Harbor

- HRSA is terminating the following sleep study center:

HRSA Approved Sleep Centers	Location
Eastside Sleep Disorders Center	Overlake Hospital Medical Center – Bellevue, WA

Smoking Cessation for Pregnant Women

Effective for dates of service on and after January 1, 2008, HRSA will cover CPT codes 99406 and 99407 for smoking cessation for pregnant women. See Section H of HRSA's *Physician-Related Services Billing Instructions* for policy and guidelines.

Codes for Unlisted Procedures (CPT codes XXX99)

Providers must bill using the appropriate procedure code. HRSA does not pay for procedures when they are judged to be less-than-effective (i.e., an experimental procedure), as reported in peer-reviewed literature (see WAC 388-501-0165). If providers bill for a procedure using a code for an unlisted procedure, it is the provider's responsibility to know whether the procedure is effective, safe, and evidence-based. HRSA requires this for all its programs, as outlined in WAC 388-501-0050. If a provider does not verify HRSA's coverage policy before performing a procedure, HRSA may not pay for the procedure.

New Authorization Forms for Requesting Tysabri® and The Vest® System

HRSA has created new forms for providers to use to request authorization for Tysabri® (procedure code J2323) and The Vest® System. Providers may download DSHS forms at: http://www1.dshs.wa.gov/msa/forms/eforms.html.

Billing Instructions Replacement Pages

Attached are replacement pages i-ii, ix- x; A.3-A.4; B.1-B.2, B.11-B.14, B.17-B.18; C.3-C.22; D.3-D.4; E.1-E.6, E.17-E.22; F.9-F.10, F.13-F.18, F.21-F.22; G.5-G.6, G.15-G.16; H.3-H.4, H.7-H.8, H.21-H.22; I.1-I.2, I.11-I.12, I.15-I.16; K.1-K.4, and K.9-K10 for HRSA's *Physician-Related Services Billing Instructions*.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

How do I get copies of billing instructions?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Where do I call/look if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

HRSA Customer Service Center for Providers
http://maa.dshs.wa.gov/provrel/
800.562.3022, option 2 (toll free)
PO Box 45535
Olympia, WA 98504-5535
Fax: 360.725.2144 or 360.586.1209

Private insurance or third party liability, other than HRSA managed care plans?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Electronic Claims Submission Information?

DSHS HIPAA web site for free software and HIPAA-compliance information:

http://maa.dshs.wa.gov/dshshipaa

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

Where do I call/look if I have questions regarding Electronic Claims Submission Information? (cont.)

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm (click on "Enrollment")

Or by calling: 800.833.2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800.833.2051.

Federal HIPAA-compliance web site with practical advice for providers and the answers to frequently-asked questions (FAQ):

http://www.cms.gov/hipaa

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility for free, call ACS at 800.833.2051or HRSA at 866.562.3022 (option #2).

You may also access the WAMedWeb tutorial at: http://maa.dshs.wa.gov/WaMedWebTutor/

Where do I send prior authorization and limitation extension requests?

Health and Recovery Services Administration
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

What forms are available to submit my authorization request?

- Basic Information Form (DSHS #13-756)
- Bariatric Surgery Request Form (DSHS #13-785)
- Out of State Medical Services Request Form (DSHS #13-787)
- Pet Scan Information Form (DSHS #13-757)
- Oral Enteral Nutrition Worksheet Prior Authorization Request (DSHS #13-743)
- Physical, Occupational, and Speech Therapy Limitation Extension Request (DSHS #13-786)
- TYSABRI (Natalizumab) J2323 Request (DSHS #13-832)
- Application for Chest Wall Oscillator (DSHS #13-841)

Noncovered Practitioners [WAC 388-531-0250]

HRSA does not reimburse for services performed by any of the following practitioners:

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.), except those employed by an FQHC or who have prior authorization to evaluate a client for bariatric surgery;
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that are not within the scope of the practitioner's license; and
- Any other licensed practitioners providing services that the practitioner is not trained to provide.

Clients Enrolled in HRSA's Managed Care Organizations

Many HRSA clients are enrolled in one of HRSA's managed care organizations (MCO). These clients have an HMO identifier in the HMO column on their DSHS Medical ID Card. They also receive an ID card from the MCO in which they are enrolled. Clients enrolled in one of HRSA's MCOs must obtain services through their MCO.

> **Note:** A client's enrollment can change monthly. Prior to serving a managed care client, make sure you receive approval from ***both*** the plan and the client's primary care provider (PCP), if required.

Send claims to the client's MCO for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 388-502-0160.

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater require a detailed report in order to be paid. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator in the fee schedule with billed charges under $1,100.00 unless requested by HRSA.

Codes for Unlisted Procedures (CPT codes XXX99)

Providers must bill using the appropriate procedure code. HRSA does not pay for procedures when they are judged to be less-than-effective (i.e., an experimental procedure), as reported in peer-reviewed literature (see WAC 388-501-0165). If providers bill for a procedure using a code for an unlisted procedure, it is the provider's responsibility to know whether the procedure is effective, safe, and evidence-based. HRSA requires this for all its programs, as outlined in WAC 388-501-0050. If a provider does not verify HRSA's coverage policy before performing a procedure, HRSA may not pay for the procedure.

Acquisition Cost (AC)

Drugs with an **AC** indicator in the fee schedule (Appendix) with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach the invoice to the claim, and if necessary, note the quantity given to the client in the *Comments* section of the claim form. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by HRSA.

Note: Bill HRSA for one unit of service only.

Conversion Factors

	7/1/04	7/1/05	7/1/06	7/1/07	1/1/08
Adult Primary Health Care	25.00	24.82	25.51	21.95	24.58
Anesthesia	20.24	20.44	20.99	21.20	21.20
Children's Primary Health Care	34.25	34.56	35.00	31.82	47.10
Clinical Lab Multiplication Factor	.797	.820	.820	.830	.830
Maternity	44.46	44.99	44.71	42.35	42.35
All Other Procedure Codes	22.67	22.71	22.93	22.03	22.03

These conversion factors are multiplied by the relative value units (RVUs) to establish the rates in this fee schedule.

Programs (Guidelines/Limitations)

Office and Other Outpatient Services

[Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

The Health and Recovery Services Administration (HRSA) covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately.

  Example: HRSA does not pay separately for ventilation management (CPT codes 94002-94004, 94660, and 94662) when billed in addition to an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

- One pre-operative E&M procedure by a physician for a dental client **prior to performing dental surgery** in an outpatient setting. You must bill using dental diagnosis codes 520.1–525.9 as the primary diagnosis when billing E&M codes for pre-op services for dental surgery, along with the appropriate pre op diagnosis codes V72.81–V72.84) as the secondary diagnosis. For clients assigned to an HRSA managed care organization, bill HRSA directly for history and physical claims for dental surgery.

  If you bill emergency room visits or office calls in combinations with laboratory, x-ray, or ancillary services, bill with diagnosis codes V72.81-V72.84 in the second diagnosis field. If one of these diagnoses is not in the second diagnosis field, HRSA pays the E&M, but denies the laboratory, x-ray, or ancillary services.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility. Nursing facility discharges (CPT code 99315 and 99316) are not included in the two-visit limitation. HRSA pays for one nursing facility discharge per client, per day.

- One physical examination per client, per 12 months for clients with developmental disabilities as identified on the DSHS Medical ID Card. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an examination.

Office and Other Outpatient Services (cont.)

- HRSA pays one new patient visit, per client, per provider or group practice.

- Preventative screening services for certain conditions are covered in other sections of these billing instructions.

Children's Primary Health Care **(CPT codes 99201-99215)**

- HRSA pays a higher payment rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that are paid at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in the Comments section of claim form. **In addition, when billing for a baby using one of the parents' PIC, you must add modifier HA to CPT codes 99201-99215 only** in order for the service to be paid at the higher fee. If the mother is enrolled in an HRSA managed care plan, newborns will be enrolled in the same managed care plan as their mother.

After Hours

After hours office codes are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. An after hours procedure billed for a client treated in a 24-hour facility (e.g., emergency room) is payable only in situations where a provider who is not already on-call is called to the facility to treat a client. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are scheduled to be on call at the time of service. The client's file must document the medical necessity and urgency of the service. Only one code for after hours services will be paid per patient, per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day.

For example: If a clinic closes at 5pm and takes a break for dinner and then opens back up from 6pm-10pm, these services are not eligible for after hours service codes.

Note: This policy does not include radiologists, pathologists, emergency room physicians, or anesthesiologists. HRSA does not pay these providers for after hour service codes.

Inpatient Visits for Hemodialysis or Outpatient Non-ESRD Dialysis Services
(CPT codes 90935 and 90937)

Procedure Codes Billed	Instructions
90935 and 90937	Bill these codes for the hemodialysis procedure with all E&M services related to the client's renal disease on the day of the hemodialysis procedure. Bill these codes for the following clients: • Clients in an inpatient setting with ESRD; or • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90935	Bill using procedure code 90935 if only one evaluation is required related to the hemodialysis procedure.
90937	Bill using procedure code 90937 if a re-evaluation(s) is required during a hemodialysis procedure on the same day.

Inpatient Visits for Dialysis Procedures Other Than Hemodialysis (e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)
(CPT codes 90945, 90947)

Procedure Codes Billed	Instructions
90945 and 90947	Bill these codes for E&M services related to the client's renal disease on the day of the procedure that includes peritoneal dialysis, hemofiltration, or continuous renal replacement. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90945	Bill using procedure code 90945 if only one evaluation is required related to the procedure.
90947	Bill using procedure code 90947 if a re-evaluation(s) is required during a procedure on the same day.

If a separately identifiable service is performed on the same day as a dialysis service, you may bill any of the following E&M procedures codes with modifier 25:

- 99201-99205 Office or Other Outpatient Visit: New Patient;
- 99211-99215 Office or Other Outpatient Visit: Established Patient;
- 99221-99223 Initial Hospital Care: New or Established Patient;
- 99238-99239 Hospital Discharge Day Management Services;
- 99241-99245 Office or Other Outpatient Consultations: New or Established Patient; and
- 99291-99292 Critical Care Services.

Critical Care (CPT codes 99291-99292)

[Refer to WAC 388-531-0450]

> **Note:** For neonatal or pediatric critical care services, see page B.10.

What is critical care?

Critical care is the direct delivery and constant attention by a provider(s) for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s); to treat single or multiple vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E&M codes.

Billing for Critical Care

When billing for critical care, providers must bill using CPT codes 99291-99292:

- For the provider's attendance during the transport of critically ill or critically injured clients 25 months of age or older to or from a facility or hospital.
- To report critical care services provided in an outpatient setting (e.g., Emergency department or office), for neonates and pediatric clients up through 24 months.
- To report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the client and cannot provide services to any other patient during the same period of time.

> **Note:** Surgery, stand-by, or lengthy consultation on a **stable** client does not qualify as critical care.

Where is critical care performed?

Critical care is usually performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

HRSA covers:

- A maximum of 3 hours of critical care per client, per day.
- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.
- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (36000, 36410, 36415, 36591, and 36600);
- Gastric intubation (43752 and 91105);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94002-94004, 94660, and 94662);
- Pulse oximetry (94760 and 94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

Note: Procedure code 43752 may be billed separately when it is the only procedure code billed.

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

HRSA covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

> **Note:** The standby physician cannot provide care or services to other clients during the standby period.

Limitations

- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

HRSA does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to Section F);
- Billed in addition to any other procedure code, with the exception of CPT codes 99431 and 99440; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99295) on the same day.

Newborn Care

To assist providers in billing CPT codes with "newborn" in the description, HRSA defines a newborn as 28 days old or younger.

HRSA covers:

- One newborn evaluation per newborn using either CPT code 99431 (hospital) or 99432 (birthing center or home births).
- Subsequent hospital care (other than initial evaluation or discharge) using CPT code 99433.
- Discharge services using either CPT code 99238 or 99239 for newborns admitted and discharged on different days.
- One newborn evaluation and discharge per newborn performed on the same day using CPT code 99435.

Note: HRSA covers circumcisions (CPT codes 54150, 54160, and 54161) ***only*** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Neonatal Intensive Care Unit (NICU)/ Pediatric Intensive Care Unit (PICU) (CPT codes 99293-99300, 99477)

[Refer to WAC 388-531-0900]

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team's activities.

HRSA covers:

- One NICU/PICU service per client, per day.
- Intensive observation, frequent interventions, and other intensive services for neonates. Use CPT code 99477 for initial hospital care, per day, when a neonate requires intensive observation, frequent interventions and other intensive services. You may report 99431 and 99477 when two distinct services are provided on the same day, but you must use modifier 25 with 99431. Bill 99431 with modifier 25 when you see a normal newborn after an uneventful delivery and then later the infant develops complications and is transferred to an intensive setting for observation, frequent interventions, and other intensive services.

- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

> **Note:** Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 (>2500 grams) or 99298-99300 (<2500 grams) must be used.

- Newborn resuscitation (CPT code 99440) in addition to NICU/PICU services.
- The provider's attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT code 99289 or 99290).
- Bill codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger

The following services and the subsequent intensive, noncritical services (with their corresponding CPT codes) are included in neonatal or pediatric critical care. Do not bill these separately:

- Bladder catheterization (51701- 51702);
- Central (36555) or peripheral vessel catheterization (36000);
- Continuous positive airway pressure (CPAP) (94660);
- Endotracheal intubation (31500);
- Initiation and management of mechanical ventilation (94002-94004);
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762);
- Lumbar puncture (62270);
- Oral or nasogastric tube placement (43752);
- Other arterial catheters (36140 and 36620);
- Umbilical arterial catheterization (36660);
- Umbilical venous catheterization (36510);
- Suprapubic bladder aspiration (51100);
- Surfactant administration, intravascular fluid administration (90760, 90761, 90780, and 90781);
- Transfusion of blood components (36430 and 36440);
- Vascular punctures (36420 and 36600); or
- Vascular access procedures (36400, 36405, and 36406).

> **Note:** Procedure code 43752 may be billed separately when it is the only procedure code billed.

Intensive (Non-Critical) Low Birth Weight Services (99298-99300)

- Report only once per day, per client, the appropriate procedure codes.
- These codes represent care beginning subsequent to the admission date.

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:

    - ✓ How to clean teeth as they erupt;
    - ✓ How to prevent baby bottle tooth decay;
    - ✓ How to look for dental disease;
    - ✓ Information on how dental disease is contracted;
    - ✓ Preventive sealant; and
    - ✓ Application of fluoride varnish, when appropriate;

- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, HRSA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are recommended between the ages of 1 and 2 years.
- One screening examination is recommended per 12-month period for children ages 2 through 6.
- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

Foster Care Children

HRSA pays providers an enhanced rate for EPSDT screening exams for foster care clients who receive their medical services through HRSA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

If the Medical ID card indicates the child is in foster care, the provider must bill one of the above screening codes with modifier 21 to receive the enhanced rate.

HRSA pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

Foster Children Initial Health Evaluation (IHE)

What is the purpose of an IHE?

The purpose of this evaluation is to identify any:

- Immediate medical, urgent mental health, or dental needs the child may have; and
- Additional health conditions of which the foster parents and caseworker should be aware.

Who is eligible?

Only clients 18 years of age and younger are eligible for an IHE.

What is included in an IHE?

An IHE includes the following:

- **Careful measurement of height, weight, and head circumference** – This may reveal growth delays or reflect poor nutritional or general health status.

- **Careful examination of the entire body to include the unclothing of each body surface at some point during the examination -** Because some children entering foster care have been victims of physical or sexual abuse, note and document the following:

  - ✓ Any signs of recent or old trauma;
  - ✓ Bruises;
  - ✓ Scars;
  - ✓ Deformities; or
  - ✓ Limitations in the function of body parts or organ systems.

- **Appropriate imaging studies to screen for a recent or healing fracture -** Consider if there is a history of physical abuse before placement or if signs of recent physical trauma are present.

- **Genital and anal examination (male or female).**

- **Laboratory tests for HIV and other sexually transmitted diseases –** Perform when indicated clinically or by history.

- **Documentation and prompt treatment of other infections and communicable diseases.**

- **Evaluation of the status of any known chronic illness -** To ensure that appropriate medications and treatments are available.

> **Note:** Discuss specific care instructions directly with the foster parents and caseworker.

What fee does HRSA pay?

Payment is set at the maximum allowable fee for children's office calls.

To view the EPSDT fee schedule, go to www.maa.dshs.wa.gov/RBRVS/index.html.

> **Note:** HRSA does not pay for an IHE on the same date of service as an EPSDT examination.

How do I bill?

When you provide a foster child with the IHE within 72 hours of entering out-of-home placement, bill HRSA using the following guidelines:

- Bill the appropriate evaluation and management (E&M) code (new patient codes 99201 – 99205 or established patient codes 99211 – 99215);
- Use ICD-9-CM diagnosis code V72.85 as the primary diagnosis; and
- Use modifier TJ.

If you bill an E&M code with the diagnosis code V72.85, but without modifier TJ, HRSA will deny the claim.

> **Important Note:** The IHE is not an EPSDT examination because it is not as complex or thorough. If you feel an EPSDT examination is necessary, perform the EPSDT examination within 72 hours of out-of-home placement and bill HRSA for the exam. The child will not require the IHE.

What are the documentation requirements?

Providers must either:

- Document the IHE on the Foster Care Initial Health Evaluation form (DSHS 13-843); or
- Include documentation in the client's record that addresses all elements addressed in the "What is included in an IHE" section of this memorandum or on the Foster Care Initial Health Evaluation form.

To view and download the Foster Care Initial Health Evaluation form, go to http://www1.dshs.wa.gov/msa/forms/eforms.html and scroll down to the appropriate form number.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining DSHS forms); **or**
- Another charting tool with equivalent information.

To obtain paper copies of the Well Child Examination forms, follow the instructions found on page C.22 of this section.

To download an electronic copy of the Well Child Examination form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
HRSA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate HRSA provider or HRSA's Managed Care Plan provider, if applicable, for medical treatment; or

- Provide the service for the client (if it is within the provider's scope of practice).

> **Note:** If the provider is using the parent's PIC code to bill Evaluation and Management (E&M) codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. HRSA reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions ***only***. HRSA does not reimburse for orthodontic treatment for other conditions.

Fetal Alcohol Syndrome (FAS) Screening

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or if there is suspicion of facial characteristics of FAS or microcephaly.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

HRSA pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Procedure Code	Limitations
97802	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Topical Fluoride **(HCPCS codes D1203 and D1204)**

HRSA covers topical fluoride for eligible clients according to HRSA's *Dental Program for Clients Through Age 20 Billing Instructions* and *Dental Program for Clients Age 21 and Older Billing Instructions*.

Special Immunization Requirements for EPSDT Exams

Retroactive with dates of service on and after May 1, 2007, HRSA pays for the administration of GARDASIL® (Human Papillomavirus [Types 6,11,16,18] Recombinant Vaccine) when providers bill with CPT code 90649 (H papilloma vacc 3 dose im) in the following manner:

- **For clients age 9-18 years of age:**

  HRSA only pays for the administration of GARDASIL® if it is obtained at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program. HRSA pays for the administration of the vaccine only and not the vaccine itself. Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90649 SL). HRSA pays $5.96 for the administration for those vaccines that are free from DOH.

- **For clients age 19 and 20 years of age:**

  Bill HRSA for the cost of the GARDASIL® vaccine itself by reporting procedure code 90649. DO NOT use modifier SL with any of the vaccines for clients 19 to 20 years of age. HRSA reimburses for the vaccine using HRSA's maximum allowable fee schedule. Bill HRSA for the vaccine administration using either CPT codes 90471 or 90472.

Note: HRSA will not reimburse for GARDASIL® for any other age group. HRSA limits payment for immunization administration to a maximum of two administration codes (e.g., one unit of 90471 and one unit of 90472).

GARDASIL® is administered in a series of three shots. To be paid by HRSA, the physician must prescribe and administer the GARDASIL® series only:

- After the physician has performed an EPSDT exam; and
- To eligible clients on Medicaid programs.

The EPSDT exam is only required prior to the first shot in the series. Clients on TAKE CHARGE, Family Planning Only, and the Alien Emergency Only program are not eligible for this service.

Immunizations - Children

(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to "Immunizations-Adults" on page C.11.)

Immunizations covered under the EPSDT program are listed in the Fee Schedule. For those vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under, HRSA pays only for the administration of the vaccine and not the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as "free from DOH."

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

Clients 18 years of age and younger – "Free from DOH"

- These vaccines are available at no cost from DOH. Therefore, HRSA pays only for administering the vaccine.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). HRSA pays $5.96 for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90465-90468 for the administration.

- If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M code. **Exception**: If an immunization is the only service provided (e.g., immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

Note: The above policy **does not** apply to E&M CPT codes 99381-99385, 99391-99395 used for EPSDT screening visits. HRSA will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M.

Clients 18 years of age and younger – "Not free from DOH"

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. HRSA reimburses for the vaccine using HRSA's maximum allowable fee schedule.

- Bill HRSA for the vaccine administration using either CPT codes 90465-90468 or 90471-90472. ***Do not*** bill CPT codes 90465-90468 in combination with CPT codes 90471-90472. HRSA limits reimbursement for immunization administration to a maximum of two administration codes (e.g., one unit of 90465 and one unit of 90466, one unit of 90467 and one unit of 90468, or one unit of 90471 and one unit of 90472).
  For example:

  ✓ One unit of 90465* and one unit of 90466*;
  ✓ One unit of 90467* and one unit of 90468*; or
  ✓ One unit of 90471 and one unit of 90472.

  Note: HRSA pays for the above starred (*) administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. HRSA pays for the vaccine using HRSA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

  Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA. Please see Section I. For clients 18 years of age and younger, HRSA does not require authorization when the vaccine is free from DOH.

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children")

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.

- HRSA reimburses providers for the vaccine using HRSA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

- If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M code. **Exception**: If an immunization is the only service provided (e.g., immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

Note: The above policy **does not** apply to E&M CPT codes 99381-99385, 99391-99395 used for EPSDT screening visits. HRSA will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M.

Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA. Please see page I.9.

Immune Globulins

Note: HRSA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis®** (CPT code 90378)

  To receive payment for Synagis®, you ***must*** do one of the following:

  ✓ Include the 11-digit National Drug Code (NDC) on the claim form when billing HRSA for Synagis® purchased by the provider and administered to the client in the provider's office. Continue to bill using CPT code 90378 for the drug itself. Bill one (1) unit for each 50 mg of Synagis® used.

  - OR -

  ✓ Obtain Synagis® from a HRSA-contracted specialty pharmacy. The pharmacy will bill HRSA directly for the drug and ship it to the provider's office for administration. Providers may then bill HRSA for the administration only. Do not bill HRSA for the drug itself when the drug is billed by the specialty pharmacy. Please check with the pharmacy regarding whether or not they are contracted to bill HRSA directly as contracted pharmacies change often.

HRSA covers Synagis® for those clients younger than one year of age from December 1 – April 30 of any given year without prior authorization (PA). HRSA requires PA for all other time periods and all other age groups. For details regarding the PA process, refer to Section I of HRSA's current *Physician-Related Services Billing Instructions*.

National Drug Code Format

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. **[WAC 388-530-1050]**

- The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros." **For example:** The label may list the NDC as 123456789when, in fact, the correct NDC is ***0***1234***0***56789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***HRSA will deny claims for drugs billed without a valid 11-digit NDC.***

  Electronic 837-P Claim Form Billing Requirements

  Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

1500 Claim Form Billing Requirements

If you bill using a **paper** 1500 Claim Form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. 54569549100 Line 2 / 00009737602 Line 3

Line	Date of Service	Procedure Code	Charges	Units
1	07/01/07	99211	50.00	1
2	07/01/07	90378	1500.00	2
3	07/01/07	J3420	60.00	1

DO NOT attempt to list more than two NDCs in field 19 on the paper 1500 Claim Form. If you bill for more than 2 drugs, you must list the additional drugs on additional claim forms. **You may not bill more than 2 drugs per claim form.**

If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

- **Rabies Immune Globulin (RIG) (cont.)**

  ✓ RIG is sold in either 2 ml or 10 ml vials.

  ✓ One dose is allowed per episode.

  ✓ Bill one unit for each 2 ml vial used per episode.

  Examples:

  ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or

  ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill HRSA for immune globulins using the HCPCS procedure codes listed below. HRSA does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

Noncovered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1566
90284	J1562
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670
~~J1567~~ **Deleted 12/31/07**	Q4087, Q4088, Q4091, and Q4092

- HRSA pays for nasal Flu vaccines (CPT 90660) from October 1-March 31 of each year.

Therapeutic or Diagnostic Injections

(CPT codes 90760-90779) [Refer to WAC 388-531-0950]

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 90772) in addition to an injectable drug code.

- HRSA does not pay separately for intravenous infusion (CPT codes 90772-90779) if they are provided in conjunction with IV infusion therapy services (CPT codes 90760, 90761, or 90765-90768).

- HRSA pays for only one "initial" intravenous infusion code (CPT codes 90760, 90765, or 90774) per encounter unless:

  - ✓ Protocol requires you to use two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second "initial" service code with modifier 59.

- HRSA does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 90760-90761, 90765-90768, or 90772-90779. If billed in combination, HRSA denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.

- **Concurrent Infusion:** HRSA pays for concurrent infusion (CPT code 90768) only once per day.

Hyalgan/Synvisc/Euflexxa/Orthovisc

- HRSA reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, or Orthovisc.

- HRSA allows a maximum of 5 Hyalgan, 3 Synvisc, 3 Euflexxa, or 3 Orthovisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

The injectable drug must be billed after all injections are completed.

- Providers must bill for Hyalgan, Synvisc, Euflexxa, and Orthovisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
J7321	Hyalgan/supartz inj per dose	Maximum of 5 injections Maximum of 5 units
J7322	Synvisc inj per dose	Maximum of 3 injections Maximum of 3 units
J7323	Euflexxa inj per dose	Maximum of 3 injections Maximum of 3 units
J7324	Orthovisc inj per dose	Maximum of 3 injections Maximum of 3 units

- Hyalgan, Synvisc, Euflexxa, and Orthovisc injections are covered only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.

- The injectable drugs must be billed after all injections are completed.

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc, Euflexxa, and Orthovisc.

- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, HRSA limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although specific memoranda have been superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02, V25.40, V25.49, or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer.
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585.1-585.9 (chronic renal failure)
J2325	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585.6 (chronic renal failure)
J2916	Na ferric gluconate complex	585.6 (chronic renal failure)
J3285	Treprostinil, 1 mg	416.0-416.9 (chronic pulmonary heart disease)
J3420	Vitamin B12 injection	123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487 J3488	Zoledronic acid	198.5, 203.00-203.01, and 275.42 (hypercalcemia)
J9041	Bortezomib injection	203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Subc inj interferon beta-1a	340 (multiple sclerosis)
J2323	Natalizumab injection	340 (multiple sclerosis). Requires PA. See Important Contacts section for information on where to obtain the authorization form.

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174.0-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).
- HRSA reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case management.
- HRSA reimburses providers for one unit of Clozaril case management per week.
- HRSA reimburses providers for Clozaril case management when billed with ICD-9-CM diagnosis codes 295.00 – 295.95 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- HRSA does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

Botulism Injections **(HCPCS code J0585 and J0587)**

HRSA requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**. HRSA requires PA for CPT code 95874 when needle electromyography for guidance is used.

HRSA approves Botulism injections with PA:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

Vivitrol

HRSA pays for Vivitrol only when billed by a pharmacy through the Point-of Sale (POS) system.

Using the On-line General Store

1. Go to the Department of Printing website at www.prt.wa.gov.

2. Click ***General Store***. Register if you are new to the site or sign in. Write down your login for future use.

3. You will be given an option to shop by agency or item type. Click ***Shop by Agency***.

4. Click ***Department of Social and Health Services***, then ***Health and Recovery Services Administration***, then ***Publications*** or ***Forms*** whichever is the product you wish to order. You will then have a list of publications or forms by number.

5. Select the item you wish and place it in your shopping cart by clicking on ***Add to Cart***.

   VERY IMPORTANT!! YOU MUST click on the ***Update Cart*** button located below your list of items in your cart. If the button is not visible due to multiple items being in your cart, use the scroll buttons on the right to scroll down until it is visible. If you do not click on the ***Update Cart*** button, you will only receive 1 of each item ordered.

6. You may continue shopping and adding items to your cart, or you may click the ***Check Out*** button.

7. Enter your shipping information on the next screen. Be sure the first time you use the cart you enter your primary shipping information. This will be Address 1 and the default information that will appear each time you check out. You may add other addresses by selecting ***New Address*** in the "Select Address" window and filling in the information. Write down what the new address number is and you can have it automatically filled in by choosing that address number. Then click the ***Total*** button.

The preferred method of ordering is on-line through the Department of Printing's General Store. You may also send orders by email to fulfillment@prt.wa.gov, by phone at 360.586.6360, or fax at 360.586.8831. Please order online if at all possible.

Useful web addresses:

- HRSA Publications website http://maa.dshs.wa.gov/CustomerPublications/
- DSHS Forms http://www1.dshs.wa.gov/msa/forms/

Exams/Refractions Due to Medical Conditions or Medication

[Refer to WAC 388-544-0250 (2)]

HRSA covers medically necessary nursing facility visits (procedure codes 99307 – 99310). There must be communication between the attending physician and the consulting specialist regarding the resident's specific needs. Group vision screenings are not covered (see *Noncovered Services* in Section D).

HRSA covers eye examinations and refraction services as often as medically necessary when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.); or

- The client is on medication that affects vision.

Exams/Refractions Due to Lost or Broken Hardware

[Refer to WAC 388-544-0250 (3)]

HRSA covers eye examinations/refractions outside the time limitations listed on page D.2 when the eye examination/refraction is necessary due to lost or broken eyeglasses/contacts. To receive payment:

- For **adults** (clients 21 years of age or older),), providers must follow the expedited prior authorization (EPA) process (see Section I – *Authorization* **EPA# 610**) and document the following in the client's file:

  - ✓ The eyeglasses or contacts are lost or broken; and
  - ✓ The last examination was at least 18 months ago;

- For **children** (clients 20 years of age or younger), HRSA does **not** require prior authorization;

- For **clients with developmental disabilities** (regardless of age), HRSA does **not** require prior authorization.

Visual Field Exams [Refer to WAC 388-544-0250 (4)]

HRSA covers visual field exams (e.g., CPT codes 92081, 92082, and 92083) for the diagnosis and treatment of abnormal signs, symptoms, or injuries.

> **Note:** HRSA does not pay for visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for HRSA clients. Your records must support the medical necessity for the visual field tests.

To receive payment, providers must document all of the following in the client's record:

- The extent of the testing;
- Why the testing was reasonable and necessary for the client; and
- The medical basis for the frequency of testing.

Coverage – Eyeglasses (Frames and/or Lenses) and Repair Services

When does HRSA cover eyeglasses (frames and/or lenses)?
[Refer to WAC 388-544-0300 (1)]

HRSA covers eyeglasses for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients with developmental disabilities** (regardless of age): Once every 12 months.

Allergen Immunotherapy

[Refer to WAC 388-531-0950(10)]

Payment for antigen/antigen preparation (CPT codes 95145-95149, 95165, and 95170) is per dose.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ One injection (CPT code 95115 or 95117); ***and*** ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; ***or*** ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

Payment for an allergist billing both an injection and either CPT code 95144 or 95165 is the injection fee plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) procedure code for conditions not related to allergen immunotherapy.

Psychiatric Services

[Refer to WAC 388-531-1400]

Note: These billing instructions are not for use by Psychologists. Refer to HRSA's *Psychologist Billing Instructions* for a description of the psychology program. To view the billing instructions online, go to http://maa.dshs.wa.gov (click ***Provider Publications/Fee Schedules*** and then ***Billing Instructions***).

General Guidelines

- HRSA pays a maximum of one psychiatric service procedure code per client, per day.

- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:

  - ✓ Brief (up to one hour) individual psychotherapy (CPT codes 90804-90807, 90810-90813*, 90816-90819, and 90823-90827*);
  - ✓ Family psychotherapy (CPT code 90847);
  - ✓ Group psychotherapy (CPT codes 90853 and 90857);
  - ✓ Electroconvulsive therapy (CPT codes 90870); or
  - ✓ Pharmacological management (CPT code 90862).

- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].

- A psychiatrist may not bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- HRSA pays psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**

- Psychiatric sleep therapy is not covered.

***Interactive psychotherapy is limited to clients 20 years of age and younger.**

Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

Inpatient Hospital

Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Inpatient Psychotherapy	90816-90822, 90823-90829*

*Codes 90823-90829 are limited to clients 20 years of age and younger.

Outpatient Hospital

Covered Procedure	CPT Codes
Observation	G0378-G0379 or 99234-99236
Psychotherapy	90804-90815
Consultation	99241-99245

Office

Covered Procedure	CPT Codes
Consultation	99241-99245
Psychotherapy	90804-90815

Other Psychiatric Services

Covered Procedure	CPT Codes
Psychiatric Diagnostic Interview	90801, 90802
Other Psychotherapy	90845, 90847, 90853
Other Psychiatric Services	90862-90870, 90899
Case Management Service • Team Conferences • Telephone Calls	 99367 99441-99443

HRSA does not pay for the following psychotherapy codes when billed with E&M codes:

90805	90807	90809	90811	90813	90815	90817
90819	90822	90824	90827	90829		

The following procedure codes are limited to clients 20 years of age and younger: 90823-90829, 90810-90815, and 90802.

Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

HRSA does not cover the following services for psychiatrists using ICD-9-CM diagnosis codes 290.0-319:

- Office visits (99201-99215);
- Emergency department visits (99281-99288);
- Nursing facility services (99304-99318);
- Domiciliary home or custodial care services (99324-99340);
- Home services (99341-99359); and
- Stand-by services (99360).

Limitations for Inpatient and Outpatient Psychiatric Services

- Admissions for acute, community psychiatric inpatient care require PA from the designated Mental Health Division Designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the prior authorization. Please see the list of RSNs at the Division of Mental Health's web site: http://www1.dshs.wa.gov/mentalhealth/rsndirectory.shtml.

- HRSA does not pay the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and you bill using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.

- HRSA pays psychiatrists and psychiatric ARNPs for only those procedure codes and diagnosis codes that are within their scope of practice.

- HRSA pays psychiatric ARNPs for the following psychiatric services only:

  - ✓ 90801 - Psychiatric Diagnostic Interview Examination;
  - ✓ 90802 - Interactive Psychiatric Diagnostic Interview Examination; and
  - ✓ 90862 - Pharmacological management.

- HRSA does not cover physician services for clients admitted for voluntary psychiatric admissions on the psychiatric indigent inpatient PII program who receive a Medical ID Card with the identifier "MIP-EMER No out-of-state care."

- HRSA limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. The following codes are included in the allowed 12 hours:

90804	90805	90806	90807	90808	90809	90810
90811	90812	90813	90814	90815	90845	90847
90853	90857	90865	90870	90899		

Note: Pharmacological management is not subject to the 12-visit limitation.

- Family therapy is covered only when the client is present.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year per provider. PA is required if a second examination is needed because of a change in a client's condition or if they have a change in legal status (i.e., voluntary to involuntary or involuntary to voluntary). CPT code 90802 is limited to those clients who are 20 years of age and younger.

- Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862).

- Individual psychotherapy, interactive services (CPT codes 90810-90813 and 90823-90827) may be billed only for clients age 20 and younger.

Involuntary Treatment Act (ITA)

For all clients involuntarily detained under Chapter 71.34 or 71.05 RCW, physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

- A copy of the Initial Certification Authorization for Admission to Inpatient Psychiatric Care form (DSHS 13-821) that a hospital completes for prior authorization from the designated RSN must accompany the claim. If the client is admitted longer than 20 days, the physician must include a copy of the Extension Certification Authorization for Continued Inpatient Psychiatric Care form (DSHS 13-822). You may view/download these forms at http://www1.dshs.wa.gov/msa/forms/eforms.html. To help decide which RSN to contact for authorization, see Section F of HRSA's *Inpatient Hospital Billing Instructions*.

- Payment is made if the date of service is within 30 days from the date of detention.

- An extension form is required after 20 days of care. Extension approvals can be from the RSN, as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- HRSA pays for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See HRSA's *Psychologist Billing Instructions* for related policy and/or procedure codes). As with all other claims, an authorization form must accompany the claim. Attaching the authorization form serves as verification of the involuntary status.

- **Out-of-state hospitals** must obtain authorization from the appropriate MHD designee for all Medicaid clients. Neither DSHS nor the MHD designee pays for inpatient services for non Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the General Assistant – Unemployable (GAU) program. For these clients, DSHS and the MHD designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

Note: One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are paid from county ITA administrative funds.

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid. HRSA pays laboratories for Medicare-approved tests only.

CLIA Certification

All reference (outside) labs and facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with HRSA in order to receive payment from HRSA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2805 or write to:

DOH - Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, WA 98155
206.361.2805 (phone); 206.361.2813 (fax)

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to the table below for those codes with both a technical and professional component.

Laboratory Physician Interpretation Codes

The following codes are clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. The actual performance of the tests is paid for under the laboratory fee schedule. Modifier TC must not be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

83020	84181	86255	86327	87207
83912	84182	86256	86334	88371
84165	85390	86320	86335	88372
84166	85576	86325	87164	89060

Laboratory Codes Requiring Modifier and PA Clarification

Laboratory claims must include an appropriate medical diagnosis code, modifier, and PA, if applicable. The ordering provider must give the appropriate medical diagnosis code, modifier, and PA number, if applicable, to the performing laboratory at the time the tests are ordered. HRSA does not pay for laboratory procedures billed using ICD-9-CM diagnosis code V72.6 as the primary diagnosis.

Cancer Screens (HCPCS codes G0101, G0103-G0105, 82270)

HRSA covers the following cancer screenings:

- Cervical or vaginal;
- Prostate; and
- Colorectal.

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0101	Females only One every 12 months *[Use for Pap smear professional services]*	V25.40-V25.49, V72.31, V76.2, or V76.47
G0103	Once every 12 months when ordered	Any valid ICD-9-CM code other than high risk (e.g., V76.44)
G0104	Clients age 50 and older who are not at high risk Once every 48 months	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0105*	Clients at high risk for colorectal cancer One every 24 months	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72, V84.09, V16.0, or V18.51
82270	N/A	Any valid ICD-9-CM code (e.g., V76.51)
G0121*	Clients age 50 and older Once every 10 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0122	Clients age 50 and older Once every 5 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)

***Note**: Per Medicare guidelines, HRSA's payment is reduced when billed with modifier 53 (discontinued procedure).

Coding and Payment Policies

- Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.
- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- HRSA pays for one blood draw fee (CPT codes 36415-36416 or 36591) per day.
- HRSA pays for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- Complete blood count (CPT code 85025) includes the following CPT codes: 85004, 85007, 85008, 85009, 85013, 85014, 85018, 85027, 85032, 85041, 85048, 85049, and G0306. Complete blood count (CPT code 85027) includes the following CPT codes: 85004, 85008, 85013, 85014, 85018, 85032, 85041, 85048, 85049, and G0307.
- CPT codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. Prior authorization is required for more than 15 tests.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Payment for lab tests includes handling, packaging and mailing fee. Separate payment is not allowed.
- Laboratories must obtain PA from the ordering physician or HRSA-approved genetic counselor to be paid for certain genetic testing that requires PA. All genetic testing must be billed with the appropriate genetic testing modifier.
- CPT code 83037 [hemoglobin glycosylated (A1C)] no longer requires PA when performed in a physician's office; however, it can be billed only once every three months.

Note: Laboratory claims must include an appropriate medical diagnosis code and PA if applicable. The ordering provider must give the appropriate medical diagnosis code, prior authorization number, and modifier, if applicable, to the performing laboratory at the time the tests are ordered. **HRSA does not pay a laboratory for procedures billed using ICD-9-CM diagnosis code V72.6 as a primary diagnosis.**

Drug Screens

HRSA pays for drug screens only when:

- ✓ Medically necessary and ordered by a physician as part of a medical evaluation; and
- ✓ The drug and/or alcohol screens are required to assess suitability for medical tests or treatment being provided by the physician.

- HRSA does not pay for drug screens to monitor any of the following:
  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
  - ✓ Suspected drug use by clients living in a residential setting such as a group home.
- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs and pregnant women in DASA-contracted treatment programs, drug screens are paid through a contract issued to one specific laboratory by DASA, not through HRSA.

Laboratory Services Referred by Community Mental Health Center (CMHC) or DASA-Contracted Providers

When CMHC or DASA-contracted providers refer clients enrolled in an HRSA managed care plan for laboratory services, the laboratory **must bill HRSA directly.** The following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is **directly** related to the client's mental health or alcohol and substance abuse;
- The laboratory service is referred by a CMHC or DASA-contracted provider who has a core provider agreement with HRSA;
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis; and
- The screen must meet the criteria above in "Drug Screens."

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or DASA-contracted referring provider identification number assigned by HRSA in the "referring provider" field of the claim form. CMHC and DASA-contracted services are excluded from HRSA's managed care contracts.

Disease Organ Panels--Automated Multi-Channel Tests

HRSA pays for CPT lab panel codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

Procedure Code	Brief Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82330	Calcium, ionized
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
85007	B1 smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc, automated

- You may bill a combination of panels and individual tests not included in the panel. ***However, do not bill separately for any individual tests that are included in the panel.*** Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see next page.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy 1500 Claim Forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, or electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed**. Enter the statement: "Additional services" in field 19 when billing on a hardcopy 1500 Claim Form or in the *Comments* section when billing electronically. Total each claim separately.

- If HRSA pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated lab tests for the same date of service on an Adjustment Request form [DSHS# 525-109]. Refer to the Important Contacts section for ordering/downloading DSHS forms. Make sure you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

Payment for Automated Multi-Channel Tests

For individual automated multi-channel tests, providers are paid on the basis of the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim form.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim form.
- Bill any other individual tests as a separate line item on the claim form.

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Payment for each test is based on Medicare's fees multiplied by HRSA's fiscal year laboratory conversion factor.

For example:

- If five individual automated tests are billed, the payment is equal to the internal code's maximum allowable fee.
- If five individual automated tests ***and*** a panel are billed, HRSA pays providers separately for the panel at the panel's maximum allowable. Payment for the individual automated tests, less any duplicates, is equal to the internal code's maximum allowable fee.

If one automated multi-channel test is billed, payment is at the individual procedure code or internal code's maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91 (see page E.24 for information on modifier 91).

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.

- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.

- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.

- HRSA does not pay for an E&M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If it is appropriate to bill the E&M code, use modifier 25.

Other Surgical Policies

- Use modifiers 80, 81, and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).

- ***Microsurgery Add On Code 69990***
  CPT indicates that code 69990 is not appropriate when using magnifying loupes or other corrected vision devices. Also, code 69990 is not payable with procedures where use of the operative microscope is an inclusive component of the procedure (i.e. the procedure description specifies that microsurgical techniques are used). CPT identifies those surgeries, which specify that microsurgical techniques are used.

  HRSA follows CPT guidelines regarding the use of the operating microscope. Do not bill code 69990 in addition to procedures where the use of the operating microscope is an inclusive component.

- HRSA pays for the following procedure codes which include breast removal and breast reconstruction for clients who have breast cancer or history of breast cancer, burns, open wound injuries, or congenital anomalies of the breast. The following list of diagnosis codes must be used; **otherwise the service requires prior authorization (PA)**. Removal of failed breast implants with ICD-9-CM diagnosis code 996.54 requires PA. HRSA will pay to remove implants (CPT codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.

- HRSA requires EPA for reduction mammoplasties (CPT code 19318) and for mastectomy for gynecomastia for men (CPT code 19300). See section I for more information.

CPT Code(s)	Description	Limitations
11960	Insertion of tissue expander(s)	Limited to ICD-9-CM diagnoses: ✓ V10.3 ✓ 174.0-175.9 ✓ 233.0 ✓ 757.6 ✓ 759.9 ✓ 879.0-879.1 ✓ 906.0 ✓ 906.8 ✓ 942.00-942.59
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19301	Removal of breast tissue	
19302	Remove breast tissue, nodes	
19303	Removal of breast	
19304	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	
S2066	Breast reconstruction w/gap flap	
S2067	Breast reconstruction	

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.10 and 633.11).

- Modifier 53 must be used when billing for incomplete colonoscopies (CPT code 45378, or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 or HCPCS codes G0105 or G0121 only. It is "informational only" for all other surgical procedures.

Urology

Circumcisions (CPT codes 54150, 54160, and 54161)

Circumcisions are covered when billed with one of the following diagnoses:

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balnitis Xerotica (ICD-9-CM 607.81).

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

Refer to Section K for those urinary tract implants covered by HRSA. **All services provided and implant codes must be billed on the same claim form**

Urological Procedures with Sterilizations in the Description

These procedures may cause the claim to stop in HRSA's payment system and trigger a manual review as a result of HRSA's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, you must note one of the following in the *Comments* section of your claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Indwelling Catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- HRSA pays providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the post-operative period of a major surgery.

Grafts

Procedure Code	Brief Description	Does not require PA when billed with ICD-9-CM diagnoses
15170	Acell graft trunk/arms/legs	940.0 – 949.5 or 906.5 – 906.9
15171	Acell graft t/arm/leg add-on	
15175	Acellular graft, f/n/hf/g	
15176	Acell graft, f/n/hf/g add-on	

Osteotomy Reconstruction

Procedure Code	Brief Description	Does not require PA when billed with ICD-9-CM diagnoses
21198		170.1 or 802.20 – 802.35

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- HRSA requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Do **not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- HRSA pays for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- HRSA pays providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with HRSA to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. An example of this includes, but is not limited to, the time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. HRSA has assigned flat fees for these codes.

- HRSA does not adopt any ASA RVG codes that are not included in the CPT book. Bill all anesthesia codes according to the descriptions published in the current CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, HRSA follows CPT code descriptions.

- HRSA does not pay providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT codes.**

  ***Exception*:** Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are paid as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01965 or 01966), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- When billing the following procedures, use only the codes indicated below:

  - ✓ Vasectomies: 00921 (not covered for clients on the TAKE CHARGE program);
  - ✓ Hysterectomies: 00846, 00944, 01962-01963, or 01969;
  - ✓ Sterilizations: 00851; and
  - ✓ Abortions: 01965 or 01966.

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, HRSA pays each provider 50% of the allowed amount. HRSA limits payment in this circumstance to 100% of the total allowed payment for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. HRSA calculates the base units.

Regional Anesthesia

- Bill HRSA the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. HRSA determines payment by using the procedure's maximum allowable fee, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the global surgical package and is not paid separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- HRSA follows Medicare's policy of not paying surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate payment** for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.

- When billing for anesthesia services using CPT **unlisted anesthesia code 01999**, **providers must attach documentation** (operative report) **to their claim** indicating what surgical procedure was performed that required the anesthesia, in order to receive payment. HRSA will determine payment amount after review of the documentation.

Anesthesia for Maternity **[Refer to WAC 388-531-0300(9)]**

- HRSA pays a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

  Exception: The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962-01966 or 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 5 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

  For Example: When a physician starts a planned vaginal delivery (CPT code 01967) and it results in a cesarean delivery (CPT code 01968), both of these procedures may be billed. However, if both an anesthesiologist and a certified registered nurse assistant (CRNA) are involved, each provider bills only for those services he/she performed. The sum of the payments for each procedure will not exceed HRSA's maximum allowable fee.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- HRSA's current anesthesia conversion factor is $21.20.
- Anesthesia time is paid using **one minute per unit**.
- Total anesthesia payment is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in **total minutes** only, rounded to the next whole minute. Do not bill the procedure's base units.

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation	
A.	Multiply base units by 15.
B.	Add total minutes to value from step A.
C.	Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D.	Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Procedure Code	Brief Description
64475*	Inj paravertebral l/s
64476*	Inj paravertebral l/s add-on
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64550*	Apply neurostimulator
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve, face muscle
64613*	Destroy nerve, spine muscle
64620*	Injection treatment of nerve
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on
64630*	Injection treatment of nerve

Procedure Code	Brief Description
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76496	Fluoroscopic procedure
77001	Fluoroguide for vein device
77002	Needle localization by xray
77003	Fluoroguide for spine inject
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refil & main

These codes are paid as a procedure using HRSA's maximum allowable fee, not with base units and time.

Major Trauma Services

Increased Payments for Major Trauma Care

The legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the Department of Social and Health Services (DSHS) receive funding from the TCF to help support provider groups involved in the state's trauma care system. DSHS uses its TCF funding to draw down federal matching funds, and pays enhanced rates to designated trauma services and physicians for trauma cases that meet specified criteria.

The supplemental payments program for trauma care was discontinued on May 5, 2002. The legislature reinstated funding for the program beginning with dates of service on and after July 1, 2003.

The enhanced rates are available for trauma services provided to fee-for-service Medical Assistance clients with Injury Severity Scores (ISS) of 13 or greater for adults and 9 or greater for pediatric (under 15 years of age).

TCF Payments to Hospitals

A **hospital** is eligible to receive TCF payments from DSHS if the hospital:

- Is designated by DOH as a designated trauma service center (or "recognized" by DOH if in a bordering city);
- Is designated as a Level 1, Level 2, or Level 3 trauma service center;
- Meets the provider requirements in WAC 388-550-5450 and other applicable WAC;
- Meets the billing requirements in WAC 388-550-5450 and other applicable WAC; and
- Submits all information DOH requires to ensure trauma services are being provided.

For a list of the Designated Trauma Services, check DOH's website at:
http://www.doh.wa.gov/hsqa/emstrauma/download/designation_list.pdf

(Continued from previous page…)

ICD-9-CM Diagnosis Codes	Condition
941.40-941.49, 941.50-941.59, 942.40-942.49, 942.50-942.59, 943.40-943.49, 943.50-943.59, 944.40-944.48, 944.50-944.58, 945.40-945.49, 945.50-945.59, 946.4, 946.5	Extensive severe burns
344.00-344.09, 707.00-707.09	Skin flaps for sacral decubitus for quads only
890.0 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

HRSA does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

> **Note**: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97761).

- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). HRSA covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.
- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.
- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.
- Cognitive testing (CPT code 96125). Allowed once per client, per calendar year.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97760). HRSA covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.
- Active wound care management involving selective and non-selective debridement (CPT codes 97597, 97598, and 97602). The following conditions apply:
  - ✓ HRSA covers one unit of CPT code 97597, 97598, and 97602 per client, per day, per wound. Providers may not bill CPT codes 97597, 97598, and 97602 in conjunction with each other for the same wound; however, CPT codes 97597, 97598, and 97602 may be billed in conjunction with each if they are for separate wounds.
  - ✓ Providers must not bill CPT codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

Note:	For multiple wounds, use modifier 59.

Billing and Reimbursement

Providers must use the following CPT code when billing for diabetes or asthma group counseling visits, subject to the limitations in the chart below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

CPT Code	Restricted to Diagnoses	Visit Limitations
99078	Diabetes: 250.00-250.93 Asthma: 493.00-493.92	Limited to four (4) one-hour units per calendar year, per client, per condition

Note: HRSA pays only for the time that a client spends in the group clinical visit.

Other Limitations:

HRSA does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E&M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) - approved diabetes education core module as long as the times documented in the medical record indicate two separate sessions.

Hyperbaric Oxygen Therapy (CPT 99183)

Hyperbaric oxygen therapy requires EPA- see section I. If the client does not meet the EPA criteria, PA is required.

Genetic Counseling and Genetic Testing

HRSA covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E&M code.

Certain genetic testing procedure codes need PA. Physicians must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly.

> **Note:** DOH approved genetic counselors provide counseling for pregnant women (fee for service and healthy option clients) up to the end of the month containing the 60th day after the pregnancy ends. This service does not require authorization. To locate the nearest DOH-approved genetic counselor call DOH at 253-395-6742.

Out-of-State Hospital Admissions **(does not include border hospitals)**

HRSA pays for emergency care at an out-of-state hospital, not including hospitals in bordering cities, only for Medicaid clients on an eligible program. See WAC 388-501-0175 for recognized bordering cities.

HRSA requires PA for elective, non-emergency care and only approves these services when:

- The client is on an eligible program (e.g., the Categorically Needy Program); and
- The service is medically necessary and is unavailable in the State of Washington.

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request Form [DSHS 13-787], with additional required documentation attached, to the HRSA Medical Request Coordinator (See *Important Contacts*).

- **Out-of-state hospitals** must obtain authorization from the appropriate MHD designee for all Medicaid clients. Neither DSHS nor the MHD designee pays for inpatient services for non Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the General Assistant – Unemployable (GAU) program. For these clients, DSHS and the MHD designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

What services are covered? [Refer to WAC 388-532-120]

Services for Women

- **A routine gynecological examination (G0101) (cervical, vaginal, and breast screening examination),** is allowed once per year as medically necessary when billed with one of the following diagnosis codes:

  - ✓ V72.31 routine gynecological exam with pap cervical smear;
  - ✓ V76.47 routine vaginal pap smear; or
  - ✓ V76.2 cervical pap smear without general gynecological exam.

  If it is necessary to see the client on the same day for a medical problem, you may bill using the appropriate E&M code (99201 – 99215) with a separately identifiable diagnosis using modifier 25. **Note:** HRSA will not pay for two E&M visits on the same day.

  Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

  Note: HRSA does not pay for preventive health exams for clients 21 years of age and older.

- **FDA-approved prescription contraception method**
  (see HRSA's *Prescription Drug Program Billing Instructions*;

- **OTC contraceptives, drugs, and supplies**
  (see HRSA's *Prescription Drug Program Billing Instructions*);

- **Maternity-related services;**

- **Abortions;**

- **Sterilization procedures when:**

  - ✓ Requested by the client; and
  - ✓ Performed in an appropriate setting for the procedure.

  (See page H.23 for instructions)

  Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Services for Women (continued)

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

Note: For HIV testing use CPT 86703. **HRSA does not cover HIV testing and counseling for Family Planning Only clients.**

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence;

- **Screening mammograms (CPT 77057)** for clients 40 years of age and older, once per calendar year. Clients 39 years of age and younger require prior authorization (see section I).

- **Colposcopy** and related medically necessary follow-up services.

- **Implanon (HCPCS code J7307)**

  HRSA pays for the contraceptive implant system, Implanon.

  To bill for Implanon, providers must:

  - Bill with ICD-9 Diagnosis V25.5;
  - Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
  - Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
  - Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
  - Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing.

Note: HRSA pays for Implanon only once every three years, per client.

Who is eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined eligible for a retroactive period (see Definitions section) covering the end of the pregnancy.

What services are covered? [Refer to WAC 388-532-530]

> **Note:** All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series, excluding V25.3).

HRSA covers the following services under the Family Planning Only program:

- **Cervical, vaginal, and breast cancer screening examination,** once per year as medically necessary. The examination must be:

  - ✓ Provided according to the current standard of care; and
  - ✓ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3).

- **FDA-approved prescription contraception methods**
  (see HRSA's *Prescription Drug Program Billing Instructions* for requirements)

- **OTC contraceptives, drugs, and supplies**
  (see HRSA's *Prescription Drug Program Billing Instructions*)

- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if it is:

  - ✓ Requested by the client; and
  - ✓ Performed in an appropriate setting for the procedure.

  > **Note:** The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:

  - ✓ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3); and
  - ✓ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence.

- **Implanon (CPT code J7307)**

  HRSA pays for the contraceptive implant system, Implanon.

  To bill for Implanon, providers must:

  ✓ Bill with ICD-9 Diagnosis V25.5;
  ✓ Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
  ✓ Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
  ✓ Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
  ✓ Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing.

  Note: HRSA pays for Implanon only once every three years, per client.

What drugs and supplies are paid under the Family Planning Only program?

HRSA pays for the following family planning-related drugs and contraceptives prescribed by a physician:

Absorbable Sulfonamides
Anaerobic antiprotozoal – antibacterial agents
Antibiotics, misc. other
Antifungal Agents
Antifungal Antibiotics
Cephalosporins – 1st generation
Cephalosporins – 2nd generation
Cephalosporins – 3rd generation
Condoms
Contraceptives, injectables
Contraceptives, intravaginal
Contraceptives, intravaginal, systemic
Contraceptives, transdermal
Diaphragms/cervical caps
Intrauterine devices
Macrolides
Nitrofuran Derivatives
Oral contraceptives
Quinolones
Tetracyclines
Vaginal Antibiotics
Vaginal antifungals
Vaginal lubricant preparations
Vaginal Sulfonamides

Smoking Cessation for Pregnant Women

HRSA pays providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care organization must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care organization will have a plan indicator in the HMO column on their Medical Identification card. Do not bill HRSA for Smoking Cessation Counseling as it is included in the managed care organizations' payment rates.

Who is eligible to be paid for smoking cessation counseling?

HRSA will pay only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is covered?

HRSA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. HRSA does not pay for counseling visits when billed with an E&M service on the same day. Exceptions: 1) The client is being seen on the same day for a medical problem and modifier 25 is billed; or 2) The client is being seen for an ante partum visit and modifier TH is used. However, HRSA does not pay for a counseling visit if the client is being seen only to confirm pregnancy. Smoking cessation and HIV/AIDS counseling may be billed on the same day. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.

HRSA covers two levels of counseling:

- Basic counseling (approximately 3 to 10 minutes) which includes Steps 1-3 on previous page; and
- Intensive counseling (longer than 10 minutes) which includes Steps 1-5 on previous page.

Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses
99406	Behav chng smoking 3-10 min	649.03 (antepartum) 649.04 (postpartum)
99407	Behav chng smoking >10 min	

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. HRSA covers pharmacotherapy for smoking cessation as follows:

- HRSA covers Zyban® only;
- The product must be prescribed by a physician, ARNP, or PA;
- The client for whom the product is prescribed must be 18 years of age or older;
- The **pharmacy provider must obtain prior authorization** from HRSA when filling the prescription for pharmacotherapy; and
- The provider must include both of the following on the client's prescription:

  ✓ The client's estimated or actual delivery date; and
  ✓ Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call the Drug Utilization and Review Section at 800.848.2842.

HIV/AIDS Counseling: HRSA covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS counseling per client, per lifetime. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. HRSA does not pay for counseling visits when billed with an E&M service on the same day. Exceptions: 1) The client is being seen on the same day for a medical problem and modifier 25 is billed; or 2) The client is being seen for an ante partum visit and modifier TH is used. However, HRSA does not pay for a counseling visit if the client is being seen only to confirm pregnancy. Smoking cessation and HIV/AIDS counseling may be billed on the same day.

Prior Authorization

[Refer to WAC 388-531-0200]

What is Prior Authorization (PA)?

The prior authorization (PA) process applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment. HRSA reviews requests for payment for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. For Community Inpatient Psychiatric Inpatient authorization, see Section F of HRSA's *Inpatient Hospital Billing Instructions*.

HRSA's PA requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written/fax; and
- Expedited prior authorization (EPA).

> **Note:** In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for bariatric surgery.

How does HRSA determine PA?

HRSA reviews PA requests in accordance with WAC 388-501-0165. HRSA utilizes evidence-based medicine to evaluate each request. HRSA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HRSA reviews all evidence submitted and will do one of the following:

- Approve the request;
- Deny the request if the requested service is not medically necessary; or
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HRSA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HRSA will deny the requested service.

When HRSA denies all or part of a request for a covered service or equipment, HRSA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action the department intends to take;
- Includes the specific factual basis for the intended action;
- Includes references to the specific WAC provision upon which the denial is based;
- Is in sufficient detail to enable the recipient to learn why the department's action was taken;
- Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;
- Includes the client's administrative hearing rights;
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

"Write or Fax" Prior Authorization (PA)

What is "write or fax" PA?

"Write or fax" PA is an authorization process available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the fee schedule. Procedures that are marked with a # sign are noncovered. HRSA does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

Forms available to request PA include:

- Basic Information Form DSHS 13-756
- Bariatric Surgery Request Form [DSHS 13-785]
- Out of State Medical Services Request Form [DSHS 13-787]
- PET Scan Information Form [DSHS 13-757]
- Oral Enteral Nutrition Worksheet Prior Authorization Request [DSHS 13-743]*
- TYSABRI (Natalizumab) J2323 Request (DSHS #13-832)
- Application for Chest Wall Oscillator (DSHS #13-841)

These forms are available at: http://www1.dshs.wa.gov/msa/forms/eforms.html

*See HRSA's Enteral Nutrition Program Billing Instructions for more information.

Code	Criteria	Code	Criteria

Strabismus Surgery
CPT: 67311-67340

631 Strabismus surgery for clients 18 years of age and older when *both* of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

Visual Exam/Refraction (Optometrists/Ophthalmologists only)
CPT: 92014-92015

610 **Eye Exam/Refraction - Due to loss or breakage:** For adults within 2 years of last exam when no medical indication exists and **both** of the following are documented in the client's record:

1) Glasses that are broken or lost or contacts that are lost or damaged; **and**
2) Last exam was at least 18 months ago.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Neuropsychological Testing
CPT: 96118 and 96119

1207 Refer to Section E for criteria.

Laboratory Testing

CPT: 83900, 83909, 88384, and 88385

1209 Limited to 15 donor screenings when both of the following criteria is met:

1) The client is undergoing or has had a hematopoietic cell transplant; and
2) The transplant is being done at an HRSA-approved Center of Excellence.

HRSA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650, WAC 388-531-0700, and WAC 388-531-1600]

The following services must be performed in an HRSA-approved Center of Excellence (COE) and **do not require prior authorization (PA)**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants. HRSA pays for organ procurement fees and donor searches. For donor searches, CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. HRSA requires PA for more than 15 tests. When billing for these donor services, you must bill using the recipient's PIC code. To bill for donor services, use the appropriate V59 series diagnosis code as the principal diagnosis code. For example, if you are billing a radiological exam on a potential donor for a kidney transplant, bill V59.4 for the kidney donor and use V70.8 as a secondary diagnosis-examination of a potential donor.

  Note: Use of V70.8 as a principal diagnosis will cause the line to be denied.

  Note: As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

- Inpatient Chronic Pain Management; or

- Sleep studies (CPT codes 95805, 95807-95811).

  Note: When billing on a paper 1500 Claim Form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

Bariatric Surgery must be performed in an HRSA-approved hospital and **requires PA**.

HRSA-Approved Sleep Study Centers

[Refer to WAC 388-531-1500]

HRSA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Center for Sleep Medicine	Mid Columbia Medical Center - Dalles, OR
Forks Community Hospital	Forks, WA
Harrison Medical Center Sleep Disorders Center	Harrison Medical Center - Bremerton, WA
Highline Sleep Disorders Center	Highline Medical Center - Burien, WA
Holy Family Sleep Center	Holy Family Hospital -Spokane, WA
Kathryn S. Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
KGH Columbia Sleep Lab	Kennewick, WA.
Lourdes Sleep Lab	Lourdes Health Network Pasco, WA
Multicare Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital and Health Center- Tacoma, WA
North Olympic Sleep Center	Silverdale, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Peace Health	St. John's Medical Center Longview, WA
Providence Sleep Health Institute	Providence Everett Medical Center - Everett, WA.
Public Hospital District No. 2 of Snohomish Co.	Stevens Sleep Center Edmonds, WA
Richland Sleep Disorders Center	Richland, WA
Sleep Center at Valley Medical Center	Valley Medical Center Renton, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorder Clinic Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Disorders Program Center	Children's Hospital and Regional Medical Center- Bellevue, WA

HRSA Approved Sleep Centers	Location
St. Clare Sleep Related Breathing Disorders Laboratory	St. Clare Hospital - Tacoma, WA
St. Frances Sleep Disorder Center	St. Frances Hospital – Federal Way, WA
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5th Suite 400 W - Spokane, WA
Tri-State Memorial Hospital Sleep Diagnostic Services	Tri-State Memorial Hospital Inc. - Clarkston, WA
UW Medicine Sleep Disorders Center at Harborview	Harborview Medical Center - Seattle, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA
Whidbey General Hospital Sleep Disorders Clinic	Oak Harbor

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the approved HRSA sleep center's provider number where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of HRSA-approved sleep center.) Enter the COE provider number in box 32 on the 1500 Claim Form. When billing electronically, note the COE provider number in the *Comments* section.
- Obtain an ENT consult for children younger than 10 years of age prior to study.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnoses for sleep studies:

327.10	327.20	327.27	780.51
327.11	327.21	327.42	780.53
327.12	327.23	327.51	780.54
327.14	327.26	347.00-347.11	780.57

Note: When billing on a paper 1500 claim form, note the COE provider number in field 32. When billing electronically, note the COE provider number in the *Comments* section.

Medical Supplies and Equipment

General Payment Policies

- HRSA pays providers for certain medical supplies and equipment (MSE) dispensed from their offices when these items are considered prosthetics and are used for a client's permanent condition (see the list beginning on page K.2).

- Most MSE used to treat a client's temporary or acute condition are considered incidental to a provider's professional services and are bundled in the office visit payment (see list beginning on page K.2). HRSA pays providers separately for only those MSE listed beginning on page K.5.

- HRSA does not pay providers separately for surgical trays, as these are bundled within the appropriate surgical procedure. The fees for these procedures include the cost of the surgical trays.

- Procedure codes for MSE that do not have a maximum allowable fee and cost less than $50.00 are paid at acquisition cost. A manufacturer's invoice must be maintained in the client's records for MSE under $50.00 and made available to HRSA upon request. **DO NOT send in an invoice with your claim** for MSE under $50.00 unless requested by HRSA.

- Procedure codes for MSE that do not have a maximum allowable fee and cost $50.00 or more are paid at acquisition cost. **You must attach a copy of the manufacturer's invoice** to your claim for MSE costing $50.00 or more.

Note: To request prior authorization for MSE, write or fax:

Health and Recovery Services Administration
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
360.586.5299 (fax)

Supplies Included in an Office Call (Bundled Supplies)

Items with an asterisk (*) in the following list are considered prosthetics when used for a client's permanent condition. HRSA pays providers for these supplies when they are provided in the office for permanent conditions **only**. They are not considered prosthetics if the condition is acute or temporary. Providers must indicate "prosthetic for permanent condition" in the *Comments* section of the claim form.

For example, if a patient has an indwelling Foley catheter for permanent incontinence and a problem develops for which the physician is required to replace the catheter, it is considered a prosthetic and is paid separately. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction is not paid separately because it is treating a temporary problem.

HCPCS Code	Brief Description
99070	Special supplies
A4206	Syringe with needle, sterile 1cc
A4207	Syringe with needle, sterile 2cc
A4208	Syringe with needle, sterile 3cc
A4209	Syringe with needle, sterile 5cc
A4211	Supplies for self-administered injections
A4212	Huber-type needle, each
A4213	Syringe, sterile, 20 CC or greater
A4215	Needles only, sterile, any size
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4252	Blood ketone test or strip
A4253	Blood glucose test, per 50 strips
A4256	Normal, low and high cal solution/chips
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box of 100
A4262	Temporary lacrimal duct implant, each
A4263	Permanent lacrimal duct implant, each
A4265	Paraffin, per pound
A4270	Disposable endoscope sheath, each
A4300	Implantable access partial/catheter
A4301	Implantable access total system
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag

HCPCS Code	Brief Description
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4365*	Adhesive remover wipes, per 50
A4367*	Ostomy belt
A4368*	Ostomy filter, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4455	Adhesive remover or solvent
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4649	Surgical supply; miscellaneous

HCPCS Code	Brief Description
A5051*	Ostomy pouch, closed; with barrier
A5052*	Ostomy pouch, closed; without barrier
A5053*	Ostomy pouch, closed; use on faceplate
A5054*	Ostomy pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Ostomy pouch, drainable; with barrier
A5062*	Ostomy pouch, drainable; without barrier
A5063*	Ostomy pouch, drainable; use on barrier
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5081*	Continent device ; plug
A5082*	Continent device ; catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5120	Skin barrier, wipe or swab
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6413	Adhesive bandage first-aid

Injectable Drug Codes

HRSA's fees for injectable drug codes are the maximum allowances used to pay covered drugs and biologicals administered in a provider's office only.

HRSA follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, HRSA prices the drug at 86% of the Average Wholesale Price (AWP). HRSA updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the HRSA effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where Medicare does not establish a rate, HRSA determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand-name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, HRSA multiplies the amount by 0.86 to arrive at the fee schedule maximum allowance.

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units, and include the correct number of units on the claim form to be paid the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or

- Retain a copy of the manufacturer's invoice in the client's record for each line item in which **billed charges** are equal to or less than $1,100.00.

Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. You must indicate that the injectable drugs came from the provider's office supply. The name, strength, and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).
- HRSA follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, HRSA continues to price the drug at 86% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code.
- Claims with HCPCS code J3490 must include the NDC and the amount of the drug administered to the client in the Comments section of the claim form, and must be billed with one unit only.
- HRSA follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, HRSA continues to price the drug at 86% of the Average Wholesale Price (AWP).

Prior Authorization

Drugs requiring written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, refer to Section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, HRSA pays providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy and two 100 mg single dose vials are used to obtain the total dosage, the total of the two 100 mg vials is paid. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If HRSA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).